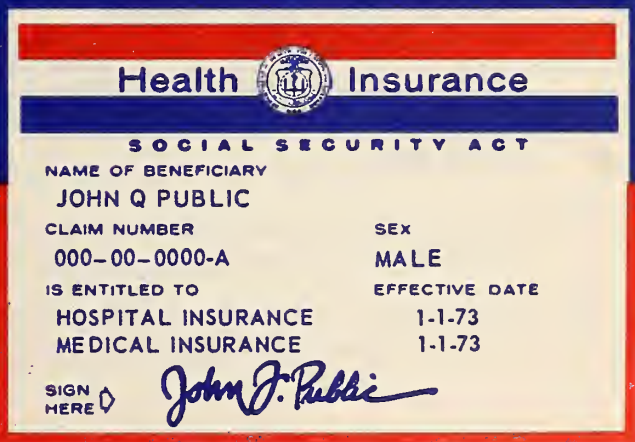
Your Medicare Handbook



HEALTH INSURANCE UNDER SOCIAL SECURITY

SSI–50
February 1973

HOSPITAL INSURANCE (PART A)
MEDICAL INSURANCE (PART B)

#1

This is *Your Medicare Handbook*. It explains the protection you have under Medicare and tells how the program works. We believe this handbook will answer most of your questions about Medicare.

Should you ever have a question about the amount Medicare paid on a bill you sent in, get in touch with the organization that handled the payment. If you have any other questions about your Medicare protection, please get in touch with your social security office.

Many changes were made in Medicare's hospital and medical insurance protection as a result of a new law passed in 1972. The most important changes have been included in this handbook.

A new edition of this handbook is being prepared which will have more details on all the recent changes. We'll mail you the new handbook later this year.

In the meantime, remember that you can get more information about your Medicare protection—or any other social security matter—at any social security office. The people there are always glad to help you.

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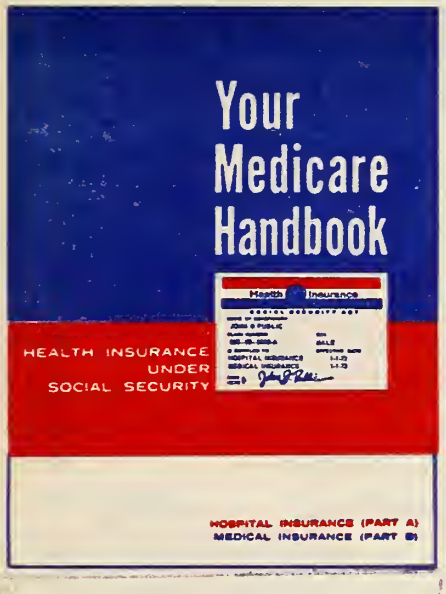


Like Medicare, your handbook has two parts. . .

PART A

• The *first* section describes *hospital insurance*, often called *Part A* of Medicare. This is the part that helps pay for your care when you are in the hospital and for related health services, when you need them, after you leave the hospital.

PART B

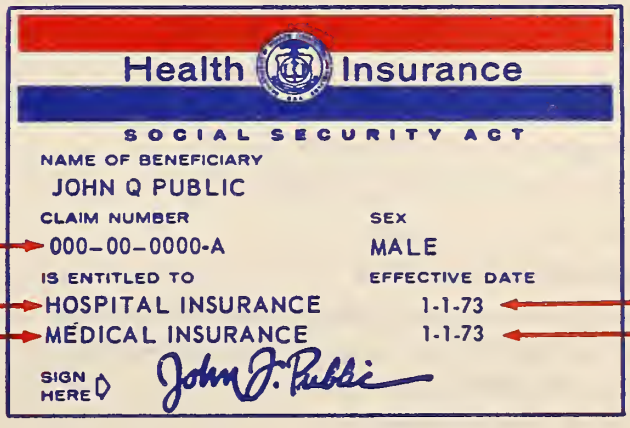
• The *second* section describes *medical insurance*, often called *Part B* of Medicare. This is the part that helps pay your doctor bills and bills for other medical services you need.

Your Medicare health insurance card shows the protection you have

The people at the hospital, doctor's office, or wherever you get services, can tell from your health insurance card that you have both hospital and medical insurance and when each started. This is why you should always have your card with you when you receive services.

When a husband and wife both have Medicare, they receive separate cards and claim numbers.

If you ever lose your health insurance card, the people in your social security office will get you a new one.



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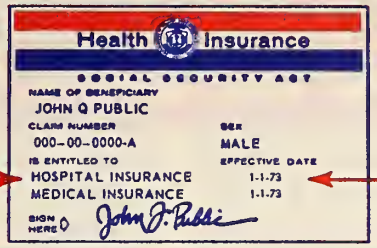


This shows that you are entitled to the benefits described in the hospital insurance part of this handbook.

The date your hospital insurance starts is shown here.

HOW HOSPITAL INSURANCE WORKS

Your hospital insurance helps pay for **medically necessary covered services provided by health facilities participating in Medicare** when you are:

- **A BED PATIENT IN A HOSPITAL,**

And . . . if you need further care *after* a hospital stay, when you are:

- **A BED PATIENT IN A SKILLED NURSING FACILITY, or**
- **A PATIENT AT HOME RECEIVING SERVICES FROM A HOME HEALTH AGENCY.**

The services hospital insurance helps pay for are called *covered services*. When you meet the conditions described on the following pages, your hospital insurance *covers almost all of the services* you would ordinarily receive as a bed patient in a participating hospital or skilled nursing facility or as a patient at home receiving services from a participating home health agency. Your hospital insurance will also, in some cases, help pay for care in certain hospitals that do not participate in Medicare (see page 12).

When you receive covered services from a participating hospital, skilled nursing facility, or home health agency, you do not need to make any claim for your hospital insurance benefits. These institutions or agencies make the claims and receive the Medicare payment. They have agreed to charge you only for services which are not covered by Medicare.

You will always receive a notice from the Social Security Administration when a payment has been made on your behalf.

All outpatient hospital services are covered only by medical insurance. See page 18.

Health Facilities Must Meet Certain Conditions to Take Part in Medicare

To participate in the Medicare program, health facilities must meet standards which help assure that they will be able to provide high quality health care. In addition, they must not charge the Medicare beneficiary for services paid for by the program, and they must abide by title VI of the Civil Rights Act, which prohibits discrimination based on race, color, or national origin.

How Often You Can Use Your Hospital Insurance Benefits—and How Your Benefits Can Be Renewed

Your use of hospital insurance benefits is limited to certain *maximum* amounts for certain periods of time—but there is a way for your hospital insurance benefits to *start over again* (except the "lifetime reserve" described on page 8). You can figure out yourself how this works:

HOW THE USE OF HOSPITAL INSURANCE BENEFITS IS COUNTED

WHEN YOU RECEIVE COVERED SERVICES AS—	YOUR PART A BENEFITS ARE—
• A bed patient in a hospital.	• Up to 90 "hospital days" for *each* "benefit period."
• A bed patient in a skilled nursing facility	• Up to 100 "extended care days" for *each* "benefit period."
• A patient at home receiving home health services.	• Up to 100 "home health visits" for *each* "benefit period." (Page 11 describes the 1-year time limit on these visits.)

These three kinds of benefits and how you qualify for them are described in more detail on the following pages. But, as you can see, you can get covered services for up to these total numbers of "days" and "visits" for *each* "benefit period." So you need to know what a "benefit period" is to know how often you can use your hospital insurance benefits.

WHAT IS A "BENEFIT PERIOD"?

A "benefit period" is simply a period of time for measuring your use of hospital insurance benefits. (In the first Medicare handbook and in some other Medicare publications, we called this period of time a "spell of illness," which is the term used in the law. But because many people thought this term had something to do with a single illness or a particular "spell" of sickness, we are now calling it a "benefit period.") This is how it works.

The first time you enter a hospital after your hospital insurance starts will be the beginning of your *first* benefit period. Your first benefit period *ends* as soon as you have not been a bed patient in any hospital (or any facility that mainly provides skilled nursing care) for *60 days in a row*. After that, a *new* benefit period begins the next time you enter a hospital—and *that* benefit period ends as soon as you have *another* 60 days in a row when you are not a bed patient in any hospital (or any facility that mainly provides skilled nursing care). Then *another* benefit period can begin the *next* time you enter a hospital—and so on.

There is no limit to the number of benefit periods you may have. There is an easy way to remember the rule. Just keep in mind that *any time* you are not in any hospital or other facility mainly providing skilled nursing care for *60* days in a row a *new* benefit period will begin the next time you go into a hospital. And, of course, for each new benefit period, your full hospital insurance benefits are available again to use as you need them.

You Get a Personal Record of Benefits Used

You don't have to bother about trying to keep track of how many "days" or "visits" you use in each benefit period. The notice you receive from the Social Security Administration after you have used any hospital insurance benefits will tell you how many benefit "days" and "visits" you have left in that benefit period. But very few people who enter a hospital or skilled nursing facility, or use home health services, need these services long enough to use all the benefits they have for a benefit period. So most people will never run out of "days" or "visits," because a new benefit period will almost always start with full benefits available again the next time they are needed.

EXAMPLE: Mr. L was in the hospital for 14 days and then went home.

After being at home for 80 days, Mr. L needs to return to the hospital. When Mr. L is admitted this time, he is in a new benefit period. That means he is again eligible for up to 90 hospital days because more than 60 days have gone by since he was last in a hospital (or other facility that mainly provides skilled nursing care). The benefit days Mr. L used the time before do not matter because he is in a new benefit period.

However, because Mr. L had been in the hospital only 14 days, he still had 76 hospital benefit days left in the original benefit period. If he had had to go back to the hospital within 60 days, instead of 80, he could have used any of these remaining days that he needed during this second stay.

How Hospital Insurance Benefits Are Financed

The hospital insurance program is financed by special contributions from employees and self-employed persons, with employers paying an equal amount. These contributions are collected along with regular social security contributions from the wages and self-employment income earned during a person's working years.

The contribution rate for the hospital insurance program is 1 percent of the first $10,800 of earnings in 1973.

These contributions are put into the Hospital Insurance Trust Fund from which the program's benefits and administrative expenses are paid. Funds from general tax revenues are used to finance hospital insurance benefits for people who are insured under a special coverage provision in the initial law even though they are not entitled to monthly social security or railroad retirement benefits. A 1972 change in the law also makes it possible for people who are not otherwise entitled to hospital insurance to enroll in the program and pay premiums into the Hospital Insurance Trust Fund.

In addition, the law provides that the various dollar amounts for which the patient is responsible be reviewed annually. These dollar amounts include the first $72 of hospital charges in each benefit period and different per-day amounts after certain periods of benefit use in hospitals and skilled nursing facilities. These are described on the following pages. The law also provides that if this annual review shows that hospital costs have changed significantly, these amounts must be adjusted for the following year.

What Hospital Insurance Can Pay When You Are a Hospital Bed Patient

When you need the kind of special care that *only* a hospital can provide, Medicare can help pay for up to 90 days of bed patient care in *each* benefit period in any participating general care, tuberculosis, or psychiatric hospital.

- For the first 60 days—hospital insurance pays for all covered services, *except for the first $72.*
- For the 61st through the 90th day—hospital insurance pays for all covered services, *except for $18 a day.*

IMPORTANT!

Once you have taken care of the ***first* $72** of hospital expenses in each benefit period, ***you do not have to pay it again,*** even if you have to go back in a hospital more than once in that same benefit period.

Also, You Have a "Lifetime Reserve" of 60 Additional Hospital Days

This is like a "bank account" of extra days to draw from if you need them. You can use them if you ever need more than 90 days of hospital care in the same benefit period. For each "lifetime reserve" day used, hospital insurance pays for all covered services, *except for $36 a day.*

Each lifetime reserve day you use permanently reduces the total you have left.

Usually you will want to use your lifetime reserve days if you need hospital care after you have used all your 90 days in a benefit period. *Unless* you decide *not* to use them, the extra days of hospital care that you use are automatically taken from your lifetime reserve.

If for any reason you do not wish to use your reserve days, the hospital will ask you to say so in writing. In making your decision, you should consider any private insurance you have which may pay for some or all of your additional hospital care. And, of course, you may wish to talk to your doctor or the people at the hospital about whether in your particular situation you should draw on your lifetime reserve.

EXAMPLE: Mrs. S had to go to the hospital a number of times in the same benefit period and used up all her 90 days. Before a new benefit period could start, she again needed to go to a hospital. She can draw from her "lifetime reserve" days to help her pay for the hospital care.

Special Rules for Benefits in Psychiatric Hospitals

For care in a psychiatric hospital, there is a lifetime limit of 190 hospital benefit days. Also, for a beneficiary who is a patient in a psychiatric hospital on the day his hospital insurance starts, there is a special limitation which is described in Question 4 on page 13.

Your Benefits When You Are a Bed Patient in a Participating Hospital

The list below describes the kinds of benefits that hospital insurance will help pay for when you are a bed patient in a hospital and some of the services that it cannot pay for.

Part A Helps Pay For:

- Bed in a semiprivate room (2-4 beds in a room) and all meals, including special diets.
- Operating room charges.
- Regular nursing services (including intensive care nursing).
- Drugs furnished by the hospital.
- Laboratory tests.
- X-ray and other radiology services.
- Medical supplies such as splints and casts.
- Use of appliances and equipment furnished by the hospital such as a wheelchair, crutches, and braces.
- Medical social services.

Part A Does NOT Pay For:

- Personal comfort or convenience items (such as charges for telephone, radio, or television furnished at your request).
- Private duty nurses.
- Any extra charge for use of a private room, unless you need it for medical reasons.
- Noncovered levels of care. (See page 13, question 8.)
- Doctors' services (medical insurance helps pay for these).

An Example of How Hospital Insurance Helps Pay for Hospital Care

Mrs. C was in the hospital for 10 days. During her stay in the hospital, Mrs. C had an operation. Her bill included the hospital charges for semiprivate room and all meals, including special diet; use of the operating room; X-rays, laboratory tests; oxygen; and drugs furnished by the hospital. There was also a charge of $15.25 for television and telephone services.

Of the total hospital bill of $967.25, Mrs. C paid $87.25. (This was the first $72 for that benefit period plus the charges for the television and telephone.) Her hospital insurance took care of the remaining $880. (And, of course, Mrs. C's medical insurance helped pay her doctor bills.)

Extended Care Benefits After You Leave the Hospital

Sometimes a patient no longer needs all the care which hospitals provide, but still needs daily skilled nursing care or skilled rehabilitation services which cannot be furnished in his home. In these cases, the doctor may transfer the patient from the hospital to a skilled nursing facility. This is a specially qualified facility which is staffed and equipped to furnish skilled nursing care or skilled rehabilitation services and many important related health services.

Hospital insurance pays for all covered services in a participating skilled nursing facility for the first 20 days you receive such services in each benefit period and all but $9 a day for up to 80 more days in that same benefit period, *but only if all the following are true*:

1. Your medical care needs require daily skilled nursing care or skilled rehabilitation services;
2. A doctor determines that you need skilled nursing or rehabilitation care and orders such care for you;
3. You have been in a participating (or otherwise qualified) hospital for at least 3 days in a row before your admission;
4. You are admitted within a limited period, generally 14 days after you leave the hospital; and
5. You are admitted for further treatment of a condition for which you were treated in the hospital.

If you leave a skilled nursing facility and are readmitted to one within 14 days, you can continue to use your additional extended care benefit days for that benefit period without a new 3-day stay in a hospital.

The following list describes some of the kinds of extended care services hospital insurance will help pay for and some of the services that it cannot pay for.

Part A Helps Pay For:

- Bed in a semiprivate room (2-4 beds in a room) and all meals, including special diets.
- Regular nursing services.
- Drugs furnished by the skilled nursing facility.
- Physical, occupational, and speech therapy.
- Medical supplies such as splints and casts.
- Use of appliances and equipment furnished by the facility such as a wheelchair, crutches, and braces.
- Medical social services.

Part A Does NOT Pay For:

- Personal comfort or convenience items (such as charges for telephone, radio, or television furnished at your request).
- Private duty nurses.
- Any extra charge for use of a private room, unless you need it for medical reasons.
- Noncovered levels of care. (See page 13, question 8.)
- Doctors' services (your medical insurance helps pay for these).

Home Health Benefits After You Leave the Hospital

After you have been in a hospital (or in a skilled nursing facility *after* a hospital stay), your doctor may decide that the continued care you need can best be given in your own home through a home health agency. If the continuing care you need in your home includes part-time skilled nursing care or physical or speech therapy, Medicare can pay for this care and also for certain additional health care services you may need.

Hospital insurance pays for all covered services—for as many as 100 home health visits after the start of one benefit period and before the start of another.

The visits must be medically necessary and be furnished by a participating home health agency. Benefits can be paid for up to a year after your most recent discharge from a hospital or participating skilled nursing facility, *but only if all the following are true*:

1. You were in a participating (or otherwise qualified) hospital for at least 3 days in a row;
2. The continuing care you need includes part-time skilled nursing care or physical or speech therapy;
3. You are confined to your home;
4. A doctor determines that you need home health care and sets up a home health plan for you within 14 days after your discharge from the hospital or a participating skilled nursing facility; and
5. The home health care is for further treatment of a condition for which you received services as a bed patient in the hospital or skilled nursing facility.

For an explanation of how "visits" are counted, see Question 7 on page 13.

The following list describes the kinds of home health services that hospital insurance will help pay for and some of the services that it cannot pay for.

Part A Helps Pay For:

- Part-time skilled nursing care, physical or speech therapy
- And if you need any of the above services, the following services are also covered:
  - Occupational therapy.
  - Part-time services of home health aides.
  - Medical social services.
  - Medical supplies and appliances furnished by the agency.

Part A Does NOT Pay For:

- Full-time nursing care.
- Drugs and biologicals.
- Personal comfort or convenience items.
- Noncovered levels of care. (See page 13, question 8.)
- Meals delivered to your home.

Benefits for Care in Hospitals That Do Not Take Part in Medicare

Nearly all hospitals in the country take part in Medicare. But if you are admitted for emergency care to a hospital that does not take part in Medicare, hospital insurance may still be able to help pay some of the bills.

Your hospital insurance can help pay for emergency care if the hospital: (1) meets certain conditions listed in the law; (2) is the closest or the quickest one to get to that has a bed available; and (3) is equipped to handle the emergency.

If you receive emergency care in such a hospital, the benefit payment will usually be made to the hospital. If the hospital decides to bill you instead of Medicare, the benefit payment will be made to you. The people at your social security office will help you make your claim.

Utilization Review

Each hospital and skilled nursing facility has a Utilization Review Committee. The purpose of this committee is to help assure the most effective use of hospital or skilled nursing facility services. The committee, which includes at least two physicians, reviews admissions on a sample basis and reviews ALL long-stay cases.

The Utilization Review Committee does not decide whether hospital or extended care services are covered under Medicare. These decisions are made by intermediaries, which are organizations selected by the Federal Government to make Medicare payment determinations.

If a Utilization Review Committee, however, finds in a specific case being reviewed that care in a hospital or skilled nursing facility is not medically necessary, then the law requires that Medicare payments must be stopped. In these cases, the committee always discusses its findings with the patient's doctor before making a decision. But, if the decision still is that further hospital or skilled nursing facility care is not medically necessary, then the patient, his doctor, and the facility are advised in writing, and Medicare payments must stop no later than 3 days after notice has been received by the hospital or skilled nursing facility.

Questions and Answers About Hospital Insurance

1. ***Where can I find out if a hospital, skilled nursing facility, or home health agency is participating in Medicare?***

   Your doctor, or someone at the institution or agency, can tell you. Or you can ask the people in any social security office.

2. ***Does hospital insurance pay for services in a foreign hospital?***

   Yes, but only under certain conditions. If you are in the United States when an emergency occurs and a foreign hospital is closer than the nearest hospital in the U.S. which could provide the emergency care you need, then hospital insurance can help pay for the emergency care. If a foreign hospital is closer to your home than the nearest U.S. hospital which can provide the care you need, hospital in-

Questions and Answers About Hospital Insurance (continued)

surance will help pay for the covered services you receive in the foreign hospital whether or not an emergency exists. Hospital insurance can also help pay for inpatient hospital care in a Canadian hospital if you become ill or are injured while you are traveling through Canada between Alaska and another State. Your medical insurance can also help pay for doctors' and ambulance services furnished in connection with covered foreign hospital care.

3. ***Can hospital insurance pay anything toward the cost of my care in a Christian Science sanatorium?***

   Yes. Your hospital insurance can cover certain hospital and extended care services furnished to inpatients of a sanatorium operated, or listed and certified, by the First Church of Christ, Scientist, in Boston. For more information, ask at any social security office.

4. ***Is there a special rule for beneficiaries who are in a psychiatric hospital when their hospital insurance protection starts?***

   Yes. When a person is a patient in a psychiatric hospital *at the time* his hospital insurance starts, the days in the mental hospital during the 150-day period just before his hospital insurance starts count against the total number of benefit days he can use in a psychiatric hospital in his first benefit period.

   These days, however, do not count against his lifetime maximum of 190 days.

5. ***What can I do if I think a mistake has been made in the amount of my hospital insurance benefits?***

   The first thing to do is to ask someone at the hospital, skilled nursing facility, or home health agency that provided the services. Usually they can answer your questions. Sometimes, however, they may need to refer you to the organization that handles their Medicare payments. If you are still not satisfied, get in touch with your social security office for information about your right to formal appeal.

6. ***What if I cannot pay the amounts that hospital insurance does not pay?***

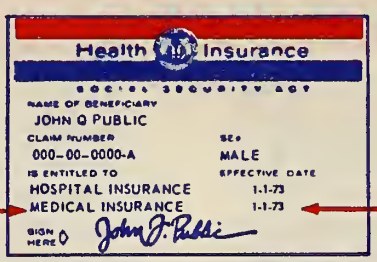
   You may want to ask at your local public assistance office about help under a State program such as old-age assistance or medical assistance (sometimes called "medicaid").

7. ***What is a home health "visit"?***

   One "visit" is counted *each* time you receive a covered health care service from a home health agency. If you receive two *different* services on the same day (for example, both a nurse and a physical therapist call on you), that would be *two* "visits." It would also be two "visits" if you received the *same* service twice in a day (such as two calls by a nurse).

8. ***What is meant by "noncovered level of care"?***

   The Medicare law specifies that payment cannot be made for custodial care. This means the level of care that primarily helps people with their personal, daily needs such as eating, getting about, and similar things one ordinarily does for himself, or that can be done for him by people without professional skills or training. When a person's *primary* need is for the skilled health care that a hospital, skilled nursing facility, or a home health agency provides, Medicare payment can be made even though personal care services are also being furnished. But if a person's *primary* need is for personal care services, Medicare cannot pay even if he is in a hospital, skilled nursing facility, or receiving home health care.



This shows that you are entitled to all the benefits described in the medical insurance part of this handbook.

The date your medical insurance starts is shown here.

YOUR MEDICAL INSURANCE PREMIUM

The basic medical insurance premium for each person is $5.80 a month through June 1973. It becomes $6.30 a month for the 12-month period starting July 1, 1973. Those who delayed signing up for a long period of time after their first chance or who signed up after canceling this insurance in the past are required by law to pay an additional 10 percent for each full year they were eligible but not enrolled.

The medical insurance program is reviewed each year to make sure that the full costs are being met. The results of the review are announced each December. Any change in your share of the premium would be effective for the 12-month period beginning the following July.

Your premium covers only part of the cost of your medical insurance protection. Up to now, the cost has been shared half and half by the people enrolled in this program and the Federal Government. Because of a recent change in the law, however, there is now a limit on how much your share of the premium can be increased.

In the future, even if the costs of the medical insurance program go up, your share can be increased only if there has been a general increase in social security cash benefits since the last time the premium was increased. The increase in your share of the premium is limited to the percentage increase in cash benefits. As a result, the Government's share may amount to more than half of the total costs in future years.

Medical insurance premiums are automatically deducted from monthly checks for people who receive social security benefits, railroad retirement benefits, or civil service annuities. People who do not receive any of these monthly checks pay their premiums directly to the Social Security Administration (or, in some cases, have premiums paid on their behalf under a State assistance program).

If You Ever Decide to Cancel

You can cancel your medical insurance at any time. Your protection and your premiums will stop at the end of the calendar quarter after the quarter your notice is received. (A calendar quarter is any of the 3-month periods beginning with January 1, April 1, July 1, or October 1.)

If you do cancel your medical insurance, you have only one chance to get it back. You may sign up again in any "general enrollment" period. There is a general enrollment period *every* year—from January 1 through March 31.

If you should ever think of canceling your medical insurance protection, remember that you may not be able to get equal protection from other sources. Many health insurance companies do not offer broad coverage policies for people 65 and over, but only *extra* insurance for those who already have medical insurance under Medicare.

HOW MEDICAL INSURANCE WORKS

Your medical insurance helps pay for—

DOCTORS' SERVICES
OUTPATIENT HOSPITAL SERVICES
MEDICAL SERVICES AND SUPPLIES
HOME HEALTH SERVICES
OUTPATIENT PHYSICAL THERAPY
SPEECH PATHOLOGY SERVICES
—and other health care services.

To understand the way medical insurance works, it will help to know the following terms.

Covered services: These are the kinds of services medical insurance can help pay for. (The reasonable charges for covered services also count toward the $60 deductible.)

$60 deductible: For each calendar year, medical insurance cannot make any payment until you have had $60 of reasonable charges for covered medical expenses. (Prior to January 1, 1973, the deductible was $50.)

Reasonable charges: Reasonable charges are determined by the Medicare carriers —the organizations selected in each State by the Social Security Administration to handle medical insurance claims—and take into consideration the customary charges of your doctor (or supplier) as well as the charges made by other doctors and suppliers in your locality for similar services.

After Medicare records show that the reasonable charges for covered services you have received are over $60 for a calendar year, medical insurance will pay 80 percent of the reasonable charges for additional covered services for the rest of that year. There are four exceptions to this rule: radiology and pathology services (page 17); home health benefits (page 20); outpatient physical therapy (page 19); and doctors' services for treatment of mental illness (Question 1, page 30). For information on when to send in claims, see page 23. *Important*: There is only *one* $60 medical insurance deductible each year —not a separate $60 deductible for each kind of covered service. Also, medical expenses in the last 3 months of one year can sometimes count toward the $60 deductible for the next year. This carry-over rule is described on page 24.

EXPLANATION OF BENEFITS NOTICE

Whenever a medical insurance claim is sent in, you will receive a statement showing your use of medical insurance benefits. This statement will show you how much of your expenses have been credited to your $60 deductible and the amount of the benefit payment if any. The explanation-of-benefits statements are important because you can use the latest one to show your doctor and others when they want to know how much of the $60 deductible you have met.

When a Doctor Treats You

Medical insurance will help pay your doctor bills for all covered services you receive in the United States. Payment can be made no matter where a doctor treats you—in a hospital, his office, skilled nursing facility, your home, or at a group practice or other clinic.

You select your own doctor. He does not have to "sign up" or make any other special arrangements with Medicare.

For covered services you receive from your doctor, the medical insurance payment can be made either to you or to your doctor. See page 22 for the two ways payment can be made.

The following list shows the kinds of doctors' services that medical insurance will help pay for and some of the services it cannot pay for.

Part B Helps Pay For:

- Medical and surgical services by a doctor of medicine or osteopathy.
- Certain medical and surgical services by a doctor of dental medicine or a doctor of dental surgery.
- Certain services by podiatrists which they are legally authorized to perform by the State in which they practice.
- Other services which are ordinarily furnished in the doctor's office and included in his bill such as:
  - Diagnostic tests and procedures
  - Medical supplies
  - Services of his office nurse
  - Drugs and biologicals which cannot be self-administered.
- Limited services by chiropractors (beginning July 1, 1973)

Part B Does NOT Pay For:

- Routine physical checkups.
- Routine foot care and treatment of flat feet and partial dislocations of the feet.
- Eye refractions and examinations for prescribing, fitting, or changing eyeglasses.
- Hearing examinations for prescribing, fitting, or changing hearing aids.
- Immunizations (unless directly related to an injury or immediate risk of infection such as a tetanus shot given after an injury).
- Services of certain practitioners, for example:
  - Christian Science practitioners
  - Naturopaths

Limited Coverage of Dental Services

Medical insurance covers the services of dentists *only* when the services involve surgery of the jaw or related structures or setting of fractures of the jaw or facial bones.

Medical insurance does *not* pay for dental services such as the care, filling, removal, or replacement of teeth, or treatment of the gum areas nor for surgery or other services related to these kinds of dental care.

Radiology and Pathology Services by Doctors When You Are a Bed Patient in a Hospital

Medical insurance pays *all* (100 percent) of the reasonable charges by doctors for radiology services (such as X-rays) and pathology services (such as blood and urine tests) you receive as an inpatient in a participating or otherwise qualified hospital.

You may not receive any doctor bills for these services because many hospitals and the doctors who perform these services have agreed that the hospital will collect the payments due from your medical insurance. If you do receive doctor bills for these services, send them in as described on page 22 for *full* payment of the reasonable charges, even though you have not met the $60 deductible.

Medical insurance pays 80 percent of the reasonable charges by doctors for all other covered services you receive. Full payment of the reasonable charges can be made only for radiology and pathology services.

SPECIAL RULE: Because the full reasonable charges are taken care of when you receive radiology and pathology services as a hospital inpatient, these charges do not count toward the $60 deductible.

Ambulance Services

Medical insurance will help pay for ambulance transportation by an approved ambulance service to a hospital or skilled nursing facility only when (1) the ambulance, its equipment, and personnel meet Medicare requirements, and (2) transportation by other means could endanger the patient's health. When the patient is taken to a facility other than the *nearest* one that can provide appropriate care, only the reasonable charges for ambulance transportation to the nearest facility can be allowed.

Under similar restrictions, medical insurance can help pay for ambulance services from one hospital to another, from a hospital to a skilled nursing facility, or from a hospital or skilled nursing facility to the patient's home.

Outpatient Hospital Benefits

When people go to the hospital for diagnosis or treatment and are not admitted as bed patients, the services they receive are called *outpatient hospital services.*

Covered outpatient services whether for diagnosis or treatment are paid by medical insurance.

After the $60 deductible has been met, Medicare takes care of 80 percent of the reasonable charges for all covered outpatient hospital services you receive.

The hospital will apply for the Medicare payment and will charge you for any part of the $60 deductible you have not met plus 20 percent of the remaining reasonable charges for the outpatient services.

If the charge is $60 or less and the hospital cannot determine how much of the $60 deductible you have met, then the hospital may ask you to pay the entire bill. If you pay the bill, any Medicare payments that are due will be paid directly to you. Except in unusual circumstances, the hospital will prepare the Medicare claim for you. If you ever need help with your claim, get in touch with your social security office.

When you pay an outpatient bill of $60 or less, here is what happens:

- *If you have already met the $60 deductible*—Medicare will pay you 80 percent of the amount you paid the hospital.
- *If you have not met the $60 deductible*—Medicare will credit the amount you paid toward your $60 deductible. If that amount plus any part of the deductible you have previously met for the year adds up to more than $60, medical insurance will pay you 80 percent of the amount above the $60 deductible.

EXAMPLE: During the year, Mrs. J had met $55 of her deductible *before* she received treatment in the hospital outpatient department. The hospital charged her $10, and she paid the bill at their request. When her claim is received, $5 of the outpatient bill is used to make up her $60 deductible and Mrs. J receives 80 percent of the remaining $5, which would be $4.

IMPORTANT:

When you go to a hospital for outpatient services, be sure to show the people there your most recent explanation-of-benefits statement (see page 15). From this form, they can tell how much of the $60 deductible you have met and how much of the deductible, if any, they may charge you.

Outpatient Hospital Benefits (continued)

The following list describes the kinds of outpatient hospital services that medical insurance will help pay for and some of the services that it cannot pay for:

Part B Helps Pay For:

- Laboratory services.
- X-ray and other radiology services.
- Emergency room and outpatient clinic services.
- Medical supplies such as splints and casts.
- Other diagnostic services.

Part B Does NOT Pay For:

- Tests given as part of a routine checkup.
- Eye refractions and examinations for prescribing, fitting, or changing eyeglasses.
- Immunizations (unless directly related to an injury or immediate risk of infection such as a tetanus shot given after an injury).
- Hearing examinations for prescribing, fitting, or changing hearing aids.

Outpatient Physical Therapy and Speech Pathology Services

Outpatient physical therapy and speech pathology services are covered by medical insurance when they are furnished under the direct and personal supervision of a doctor or when they are furnished as part of covered home health services. Starting July 1, 1973, home and office services furnished by a licensed physical therapist are covered under your medical insurance subject to an annual payment limit of $80.

Also, physical therapy or speech pathology services you receive as an outpatient are covered when they are furnished by a qualified hospital, skilled nursing facility, home health agency, clinic, rehabilitation agency, or public health agency, and they are furnished under a plan established and periodically reviewed by a doctor. This benefit can also help pay for physical therapy you need while you are a bed patient in a hospital or skilled nursing facility, when your care cannot be covered by hospital insurance.

Emergency Outpatient Care from Certain Nonparticipating Hospitals Can also be Covered

If you receive emergency outpatient care from a nonparticipating hospital which meets certain conditions, the hospital will usually bill Medicare for its share of the charges. It will then bill you for any part of the $60 deductible you have not met plus 20 percent of the remaining reasonable charges.

The hospital may choose instead to bill you for the entire amount. In this case, your medical insurance will pay you 80 percent of the reasonable charges (after the $60 deductible has been met).

For help in making your claim, get in touch with your social security office.

Home Health Benefits

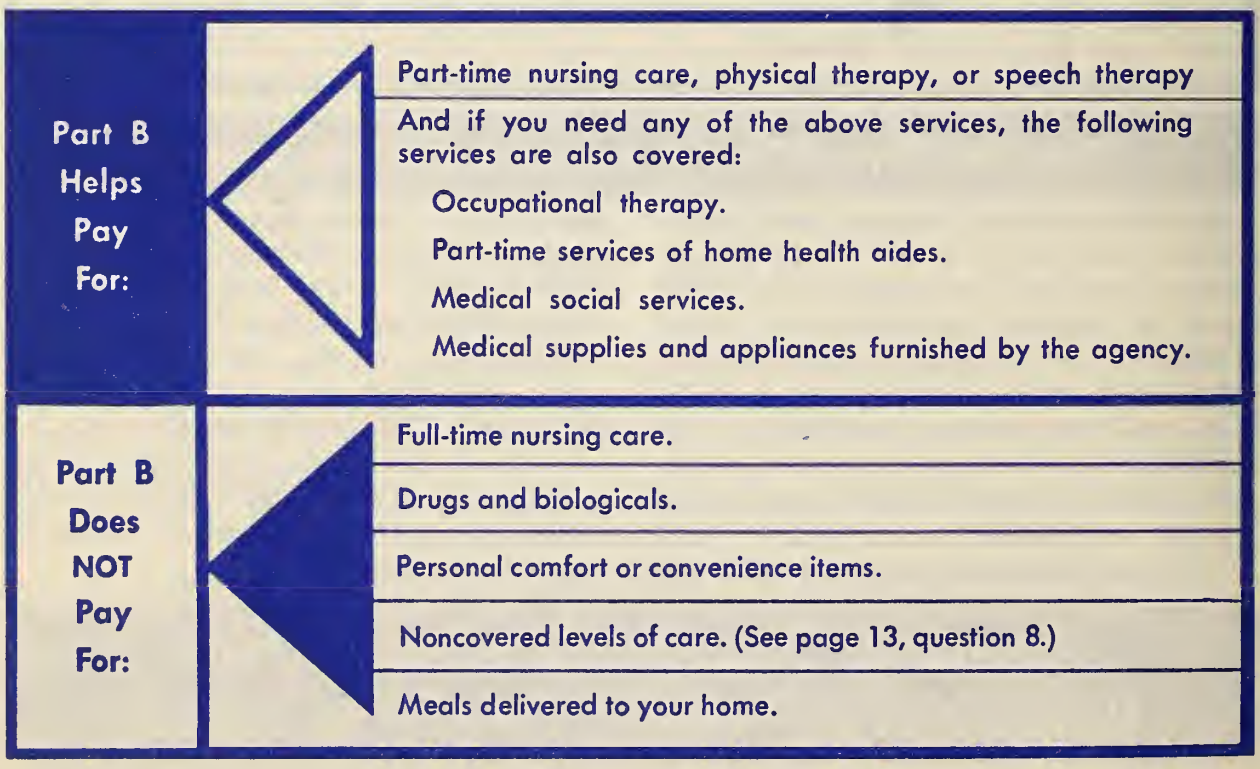
Your medical insurance will help pay for up to 100 home health visits each calendar year without the prior hospitalization required under your hospital insurance, *but only if all the following are true:*

1. You need part-time skilled nursing care, or physical or speech therapy services;
2. You are confined to your home;
3. A doctor determines you need home health care;
4. A doctor sets up and periodically reviews the plan for home health care; and
5. The home health agency is participating in Medicare.

For an explanation of how home health "visits" are counted, see Question 7 on page 13.

The home health agency always makes the claim for the benefit payment, so you do not submit a *Request for Medicare Payment* form when you receive home health services. Since medical insurance pays the *full* reasonable charges for home health services, the agency will bill you only for any part of the $60 deductible you have not met.

The following list describes the kinds of home health services that medical insurance will help pay for and some of the services that it cannot pay for.



Other Medical Services and Supplies

This benefit helps you pay for a number of different medical services and supplies which may be necessary in the treatment of an illness or injury. They may be furnished in connection with treatment by your doctor, a medical clinic, or other health facility.

When you get any of these separate services from a participating hospital, skilled nursing facility, or home health agency, it will make the claim for the Medicare payment and will bill you for any of the $60 deductible you have not met and 20 percent of the remaining reasonable charges. Otherwise, you or the supplier of services will make the claim, as described on page 22.

The following list shows the kinds of medical services and supplies that medical insurance can help pay for when they are medically necessary and ordered by your doctor and some that it cannot pay for.

Part B Helps Pay For:

- Diagnostic laboratory tests furnished by approved independent laboratories.*
- Radiation therapy and diagnostic X-ray services.*
- Portable diagnostic X-ray services furnished in your home under a doctor's supervision.
- Surgical dressings, splints, casts, and similar devices.*
- Rental or purchase of durable medical equipment prescribed by a doctor to be used in your home: for example, a wheelchair, crutches, or oxygen equipment.
- Devices (other than dental) to replace all or part of an internal body organ. This includes corrective lenses after a cataract operation and certain colostomy equipment and supplies.
- Certain ambulance services (see page 17).

Part B Does NOT Pay For:

- Prescription drugs and drugs you can administer yourself. For example, insulin injections for a diabetic condition.
- Hearing aids.
- Eyeglasses.
- False teeth.
- Orthopedic shoes or other supportive devices for the feet—except when shoes are a part of leg braces.

* If you are a patient in a hospital or skilled nursing facility and, for some reason, your hospital insurance cannot pay for these services (for example, because you have used up your benefit days), medical insurance can help pay for them.

How to Claim Medical Insurance Benefits

1. PAYMENT TO YOUR DOCTOR OR SUPPLIER

If you and your doctor (or supplier) agree that he will apply for the medical insurance payment, it will be made directly to him. This is called "assignment" of the benefit.

A. Complete and sign Part I of the *Request for Medicare Payment* (Form SSA-1490). A copy of this form is on page 25. Often your doctor's office or the supplier will complete Part I as a convenience to you.

B. Your doctor or supplier completes Part II of the form.

C. Your doctor or supplier sends in the *Request for Medicare Payment* form.

When your doctor or supplier accepts assignment, he agrees that his total charge will not exceed the reasonable charge (see page 15). This means that you are responsible only for any of the $60 deductible not yet met, plus 20 percent of the balance of the "reasonable charges" and any charges for services that Medicare does not cover.

2. PAYMENT TO YOU

If either you or the doctor (or supplier) do not want to use the assignment method, the medical insurance payment can be made directly to you. ***You can make a claim whether or not the bill has been paid.***

A. Complete and sign Part I of the *Request for Medicare Payment* form. Often your doctor's office or the supplier will complete Part I as a convenience to you.

B. Your doctor or supplier will either complete Part II or give you an itemized bill. An itemized bill shows the date, place, and description of each service, and the charge for each service. (Be sure your name and claim number, including the letter at the end, are on each bill exactly as they are shown on your health insurance card.)

C. You send in the *Request for Medicare Payment*, with either Part II completed or with itemized bills, to the organization which handles claims for the *area where you received services*. These organizations are listed on pages 27 to 29.

NOTE:

You may send in a number of bills from the *same* doctor or supplier (or from different doctors or suppliers) with a single *Request for Medicare Payment* form.

Also, if you have health insurance in addition to Medicare or you are covered under a State program which pays all or part of your health care, be sure to fill in Item 5 of your *Request for Medicare Payment* form. (See page 25.)

When to Send in Your First Claim Each Year

As soon as your bills come to $60, send them to the office that will be handling your medical insurance claims (see page 27). If the reasonable charges for covered services are $60 or more, an entry will be made in your record to show that you have met the deductible for the year, and any payment due at the time will be made.

In some cases, of course, you may want to send in your bills before you have a total of $60. For example, you may already have $40 in small medical bills when you receive services from a doctor for $25 and he agrees to take your assignment. In that case, you would send in your $40 in prior bills, so that when the assignment is processed for payment the record will show that you have met $40 of the $60 deductible. Also, you need not wait to send in a doctor's bill which meets the special rule for radiology or pathology services described on page 17.

It's a good idea to keep a record of your claim in case you ever want to inquire about it. Before you send it in, write down the date you mailed it, the services you received, the date and charge for each, and the name of the doctor or supplier who performed the services.

Your social security office will always be glad to answer your questions about when to send in your first claim.

If You Belong to a Group Practice Prepayment Plan

Group practice prepayment plans represent a special way of making health services available to their members. Generally, each member pays regular premiums to the plan in advance and this entitles him to receive any of the health services the plan provides, whenever he needs them, without paying a separate fee for each health service he receives. Congress took steps to assure that these plans could participate in the Medicare program while continuing their established method of operation.

Almost all group practice prepayment plans have made special arrangements with the Social Security Administration to receive direct payment for covered services they furnish their members who are medical insurance beneficiaries.

If you are a member of a plan which has made these special arrangements:

You **DO NOT** need to make a claim for any covered services which are provided through your group practice prepayment plan.

You **DO** need to make a claim for any covered services you receive which are not provided by your plan. In making your claim, you use one of the two methods described on page 22.

In addition, each plan has developed special methods to credit your membership premium payments or your use of plan services to the $60 deductible. Your plan will, of course, advise you of its method.

If you need more information, get in touch with your group practice prepayment plan.

When the Carry Over Helps You

To help the beneficiary who might otherwise need to meet the annual deductible twice in a short period, there is a special carry-over rule.

If you have expenses in the last 3 months of a year which can be counted toward your deductible for that year, they can also be counted toward the $60 annual deductible for the next year. This is called the carry over. So, even if you have not met the deductible before October, be sure to send in *all* the bills for covered services you receive in October, November, or December. The carry over will be credited to your deductible for both years.

Time Limits for Payment of Claims

Claims *must* be submitted within specific time limits or Medicare payment *cannot* be made. *Medicare can pay your claim only if it is sent in within the time limits shown below:*

If services were received during this period	Claims must be sent in no later than
October 1, 1971 — September 30, 1972	December 31, 1973
October 1, 1972 — September 30, 1973	December 31, 1974
October 1, 1973 — September 30, 1974	December 31, 1975

The Request for Payment Form

Page 25 shows the *Request for Medicare Payment* form. If you do not have a claim form, you can use the form on page 25. Just cut it out along the line. Generally, when you send a claim to the carrier, you will get back a new *Request for Medicare Payment* form to use for your next claim. Also, most doctors' offices usually have a supply of the forms. And you can always get extra copies from your social security office.

REQUEST FOR MEDICARE PAYMENT

Form Approved
OMB No.
72-R0730

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT (See Instructions on Back—Type or Print Information)

NOTICE—Anyone who misrepresents or falsifies essential information requested by this form may upon conviction be subject to fine and imprisonment under Federal Law.

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

When completed, send this form to:

Copy from YOUR OWN HEALTH INSURANCE CARD (See example on back)

1 Name of patient (First name, Middle initial, Last name)

2 Health insurance claim number (Include all letters)

☐ Male ☐ Female

3 Patient's mailing address — City, State, ZIP code — Telephone Number

4 Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below)

Was your illness or injury connected with your employment? ☐ Yes ☐ No

5 If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request, give the following information.

Insuring organization or State agency name and address — Policy or Medical Assistance Number

6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

SIGN HERE ➧ Signature of patient (See instructions on reverse where patient is unable to sign) — Date signed

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given	D. Nature of illness or injury requiring services or supplies	E. Charges (If related to unusual circumstances explain in 7C)	Leave Blank
				$	

8 Name and address of physician or supplier (Number and street, city, State, ZIP code)

Telephone No.

Physician or supplier code

9 Total charges $

10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill ➧ ☐ I accept assignment (See reverse) ☐ I do not accept assignment.

13 Show name and address of facility where services were performed (If other than home or office visits)

14 Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction) ➧ — Date signed

*O—Doctor's Office
IL—Independent Laboratory
H—Patient's Home (If portable X-ray services, identify the supplier)
IH—Inpatient Hospital
ECF—Extended Care Facility
OH—Outpatient Hospital
OL—Other Locations
NH—Nursing Home

FORM SSA-1490 (8-72)

Department of Health, Education, and Welfare
Social Security Administration

Cut along this line.

HOW TO FILL OUT YOUR MEDICARE FORM

There are two ways that Medicare can help pay your doctor bills

One way is for Medicare to pay your doctor.—If you and your doctor agree, Medicare will pay him directly. This is the assignment method. You do not submit any claim; the doctor does. All you do is fill out Part I of this form and leave it with your doctor. Under this method the doctor agrees to accept the charge determination of the Medicare carrier as the full charge; you are responsible for the deductible and coinsurance. Please read Your Medicare Handbook to help you understand about the deductible and coinsurance. (Because Medicare has special payment arrangements with group practice prepayment plans these plans handle all claims for covered services they furnish to their members.)

The other way is for Medicare to pay you.—Medicare can also pay you directly—before or after you have paid your doctor. If you submit the claim yourself, fill out Part I and ask your doctor to fill out Part II. If you have an itemized bill from him, you may submit it rather than have him complete Part II. (This form, with Part I completed by you, may be used to send in several itemized bills from different doctors and suppliers.) Bills should show who furnished the services, **the patient's name and number,** dates of services, where the services were furnished, a description of the services, and charges for each separate service. It is helpful if the diagnosis is also shown. Then mail itemized bills and this form to the address shown in the upper left-hand corner. If no address is shown there, use the address listed in Your Medicare Handbook—or get advice from any social security office.

SOME THINGS TO NOTE IN FILLING OUT PART I (Your doctor will fill out Part II.)

1 & **2** Copy the name and number and indicate your sex exactly as shown on your health insurance card. Include the letters at the end of the number.

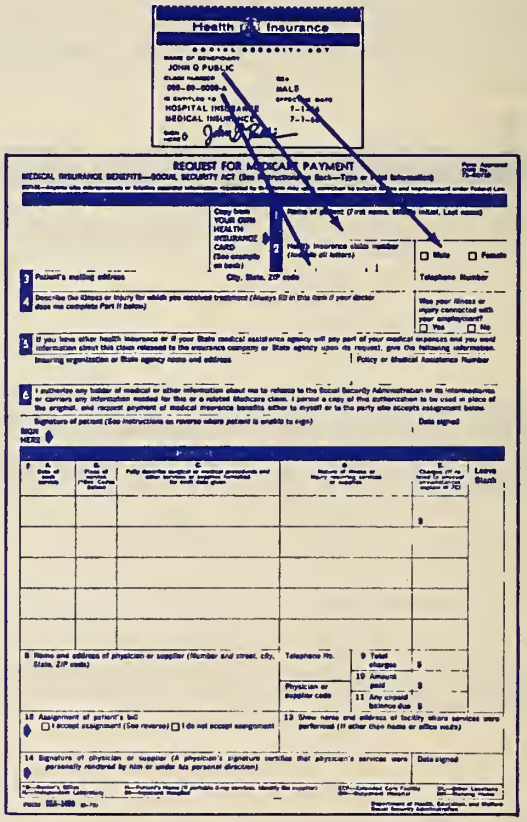
3 Enter your mailing address and telephone number, if any.

4 Describe your illness or injury. Be sure to check one of the two boxes.

5 If you have other health insurance or expect a welfare agency to pay part of the expenses, complete item 5.

6 Be sure to sign your name. If you cannot write your name, sign by mark (X), and have a witness sign his name and enter his address on this line.

If the claim is filed for the patient by another person he should enter the patient's name and write "By," sign his own name and address in this space, show his relationship to the patient, and why the patient cannot sign. (If the patient has died, the survivor should contact any social security office for information on what to do.)



IMPORTANT NOTES FOR PHYSICIANS AND SUPPLIERS

Item 12: In assigned cases the patient is responsible only for the deductible, coinsurance, and non-covered services. Coinsurance and the deductible are based upon the charge determination of the carrier if this is less than the charge submitted.
This form may also be used by a supplier, or by the patient to claim reimbursement for charges by a supplier for services such as the use of an ambulance or medical appliances.

If the physician or supplier does not want Part II information released to the organization named in item 5, he should write "No further release" in item 7C following the description of services.

Where to Send Your Claim

The list below gives the names and addresses of the organizations selected by the Social Security Administration to handle medical insurance claims. These organizations are called carriers. In most cases, carriers handle claims for an entire State; a few handle claims for only part of a State. To find out where to send your medical insurance claim, look in the list for the State *where you received the services.* Under the name of the State (or, in some cases, under the list of counties within a State), you will find the name of the organization that will handle your medical insurance claim.

If you are not sure where your first claim should go and happen to send your claim to the wrong office, don't worry. Your claim will be sent on to the right place. Be sure to include the word "Medicare" in the carrier's address on the envelope, and give *your* return address.

NOTE: If you are a railroad annuitant (even if you are also entitled to social security benefits), send your medical insurance claim to The Travelers Insurance Company office which is nearest to your home—no matter where you received services.

ALABAMA
Medicare
Blue Cross-Blue Shield of Alabama
930 South 20th Street
Birmingham, Alabama 35205

ALASKA
Medicare
Aetna Life & Casualty
522 SW. Fifth Street
Portland, Oregon 97204

ARIZONA
Medicare
Aetna Life & Casualty
3010 West Fairmount Avenue
Phoenix, Arizona 85017

ARKANSAS
Medicare
Arkansas Blue Cross and Blue Shield
P.O. Box 2181
Little Rock, Arkansas 72203

CALIFORNIA
Counties of:
Los Angeles, Orange, San Diego, Ventura, San Bernardino, Imperial, San Luis Obispo, Riverside, Santa Barbara
Medicare
Occidental Life Insurance Co. of California
Box 54905
Los Angeles, California 90054

Rest of State:
Medicare
California Blue Shield
P.O. Box 7968, Rincon Annex
San Francisco, California 94119

COLORADO
Medicare
Colorado Medical Service, Inc.
P.O. Box 6410
Denver, Colorado 80206

CONNECTICUT
Medicare
Connecticut General Life Insurance Co.
71 Catlin St.
Meriden, Connecticut 06450

DELAWARE
Medicare
Blue Cross and Blue Shield of Delaware
201 West 14th Street
Wilmington, Delaware 19899

DISTRICT OF COLUMBIA
Medicare
Medical Service of D.C.
550—12th St., S.W.
Washington, D.C. 20024

FLORIDA
Medicare
Blue Shield of Florida, Inc.
P.O. Box 2525
Jacksonville, Florida 32201

GEORGIA
The Prudential Insurance Co. of America
Medicare Part B
P.O. Box 7340, Station C
1175 Peachtree St., N.E.
Atlanta, Georgia 30309

HAWAII
Medicare
Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812

IDAHO
Medicare
The Equitable Life Assurance Society
P.O. Box 8048
Boise, Idaho 83707

ILLINOIS
County of:
Cook
Medicare
Illinois Medical Service
233 N. Michigan Street
Chicago, Illinois 60601

ILLINOIS (continued)

Rest of State:
Medicare
Continental Casualty Co.
P.O. Box 910
Chicago, Illinois 60690

INDIANA
Medicare
Mutual Medical Insurance, Inc.
120 West Market Street
Indianapolis, Indiana 46204

IOWA
Medicare
Iowa Medical Service
324 Liberty Building
Des Moines, Iowa 50307

KANSAS

Counties of:

Johnson	Wyandotte

Medicare
Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Rest of State:
Medicare
Kansas Blue Shield
P.O. Box 953
Topeka, Kansas 66601

KENTUCKY
Medicare
Metropolitan Life Insurance Co.
1218 Harrodsburg Road
Lexington, Kentucky 40501

LOUISIANA
Medicare
Pan-American Life Insurance Co.
P.O. Box 60450
New Orleans, Louisiana 70160

MAINE
Medicare
Union Mutual Life Insurance Co.
2211 Congress St.
Portland, Maine 04112

MARYLAND

Counties of:

Montgomery	Prince Georges

Medicare
Medical Service of D.C.
550—12th St., S.W.
Washington, D.C. 20024

Rest of State:
Medicare
Maryland Blue Shield, Inc.
700 East Joppa Rd.
Towson, Maryland 21204

MASSACHUSETTS
Medicare
Massachusetts Blue Shield, Inc.
P.O. Box 2194
Boston, Massachusetts 02110

MICHIGAN
Medicare
Michigan Medical Service
P.O. Box 2201
Detroit, Michigan 48231

MINNESOTA

Counties of:

Anoka	Olmstead
Dakota	Ramsey
Filmore	Wabasha
Goodhue	Washington
Hennepin	Winona
Houston	

Medicare
The Travelers Insurance Company
8120 Penn Avenue, South
Bloomington, Minnesota 55431

Rest of State:
Medicare
Blue Shield of Minnesota
P.O. Box 7899
Minneapolis, Minnesota 55404

MISSISSIPPI
Medicare
The Travelers Insurance Co.
P.O. Box 22545
Jackson, Mississippi 39205

MISSOURI

Counties of:

Andrew	Henry
Atchison	Holt
Bates	Jackson
Benton	Johnson
Buchanan	Lafayette
Caldwell	Livingston
Carroll	Mercer
Cass	Nodaway
Clay	Pettis
Clinton	Platte
Daviess	Ray
DeKalb	St. Clair
Gentry	Saline
Grundy	Vernon
Harrison	Worth

Medicare
Blue Shield of Kansas City
P.O. Box 169
Kansas City, Missouri 64141

Rest of State:
Medicare
General American Life Insurance Co.
P.O. Box 505
St. Louis, Missouri 63166

MONTANA
Medicare
Montana Physicians' Service
P.O. Box 2510
Helena, Montana 59601

NEBRASKA
Medicare
Mutual of Omaha Insurance Co.
P.O. Box 456, Downtown Station
Omaha, Nebraska 68101

NEVADA
Medicare
Aetna Life & Casualty
P.O. Box 3077
Reno, Nevada 89505

NEW HAMPSHIRE
Medicare
New Hampshire-Vermont Physician Service
Two Pillsbury Street
Concord, New Hampshire 03301

NEW JERSEY
Medicare
The Prudential Insurance Co. of America
P.O. Box 6500
Millville, New Jersey 08332

NEW MEXICO
Medicare
The Equitable Life Assurance Society
P.O. Box 3070, Station D
Albuquerque, New Mexico 87110

NEW YORK

Counties of:

Bronx	Orange
Columbia	Putnam
Delaware	Richmond
Dutchess	Rockland
Greene	Suffolk
Kings	Sullivan
Nassau	Ulster
New York	Westchester

Medicare
United Medical Service, Inc.
Two Park Avenue
New York, New York 10016

County of:
Queens
Medicare
Group Health, Inc.
227 West 40th Street
New York, New York 10018

Counties of:

Livingston	Seneca
Monroe	Wayne
Ontario	Yates

Medicare
Genesee Valley Medical Care, Inc.
41 Chestnut Street
Rochester, New York 14604

NEW YORK (continued)

Counties of:

Allegany, Cattaraugus, Erie, Genesee, Niagara, Orleans, Wyoming

Medicare
Blue Shield of Western New York, Inc.
298 Main Street
Buffalo, New York 14202

Counties of:

Albany, Broome, Cayuga, Chautauqua, Cheming, Chenango, Clinton, Cortland, Essex, Franklin, Fulton, Hamilton, Herkimer, Jefferson, Lewis, Madison, Montgomery, Oneida, Onondaga, Oswego, Otsego, Rensselaer, Saratoga, Schenectady, Schoharie, Schuyler, Steuben, St. Lawrence, Tioga, Tompkins, Warren, Washington

Medicare
Metropolitan Life Insurance Co.
258 Genesee Street
Utica, New York 13502

NORTH CAROLINA

Medicare
The Prudential Insurance Co. of America
Medicare B Division
P.O. Box 1482
High Point, North Carolina 27261

NORTH DAKOTA

Medicare
North Dakota Physicians Service
301 Eighth Street, South
Fargo, North Dakota 58102

OHIO

Medicare
Nationwide Mutual Insurance Co.
P.O. Box 57
Columbus, Ohio 43216

OKLAHOMA

Medicare
Aetna Life & Casualty
7 South Harvey
Oklahoma City, Oklahoma 73102

OREGON

Medicare
Aetna Life & Casualty
522 SW. Fifth Street
Portland, Oregon 97204

PENNSYLVANIA

Medicare
Pennsylvania Blue Shield
Box 65
Camp Hill, Pennsylvania 17011

RHODE ISLAND

Medicare
Physicians' Service
444 Westminster Mall
Providence, Rhode Island 02901

SOUTH CAROLINA

Medicare
Blue Shield of South Carolina
Drawer F, Forest Acres Branch
Columbia, South Carolina 29206

SOUTH DAKOTA

Medicare
South Dakota Medical Service, Inc.
711 North Lake Avenue
Sioux Falls, South Dakota 57102

TENNESSEE

Medicare
The Equitable Life Assurance Society
P.O. Box 1465
Nashville, Tennessee 37202

TEXAS

Medicare
Group Medical and Surgical Service
P.O. Box 22147
Dallas, Texas 75222

UTAH

Medicare
Blue Shield of Utah
P.O. Box 270
Salt Lake City, Utah 84110

VERMONT

Medicare
New Hampshire-Vermont Physician Service
Two Pillsbury Street
Concord, New Hampshire 03301

VIRGINIA

Counties of:

Arlington, Fairfax

City of:

Alexandria

Medicare
Medical Service of D.C.
550—12th St., S.W.
Washington, D.C. 20024

Rest of State:

Medicare
The Travelers Insurance Co.
P.O. Box 26463
Richmond, Virginia 23230

WASHINGTON

Medicare
Washington Physicians' Service
Mail to your local Medical Service Bureau

WEST VIRGINIA

Medicare
Nationwide Mutual Insurance Co.
P.O. Box 3183
Charleston, West Virginia 25332

WISCONSIN

County of:

Milwaukee

Medicare
Surgical Care
P.O. Box 2049
Milwaukee, Wisconsin 53201

Rest of State:

Medicare
Wisconsin Physicians Service
Box 1787
Madison, Wisconsin 53701

WYOMING

Medicare
The Equitable Life Assurance Society
P.O. Box 628
Cheyenne, Wyoming 82001

PUERTO RICO

Medicare
Seguros De Servicio De Salud De Puerto Rico
G.P.O. Box 3628
Hato Rey, Puerto Rico 00936

VIRGIN ISLANDS

Medicare
Seguros De Servicio De Salud De Puerto Rico
G.P.O. Box 3628
Hato Rey, Puerto Rico 00936

AMERICAN SAMOA

Medicare
Hawaii Medical Service Assn.
P.O. Box 860
Honolulu, Hawaii 96808

GUAM

Medicare
Aetna Life & Casualty
P.O. Box 3947
Honolulu, Hawaii 96812

Questions and Answers about Medical Insurance

1. ***Is there a limit on what medical insurance will pay for doctors' services when the services are mainly for the treatment of mental illness?***
   Yes. When such services are furnished outside a hospital, the payment is limited to a maximum of $250 a year.

2. ***Who makes the decision whether to rent or purchase durable medical equipment my doctor has prescribed for use in my home?***
   You do. When considering purchase, particularly of expensive equipment, you should keep in mind that the Medicare payments are made over a period of time, based on the reasonable rental rate for the equipment, and that these payments stop when your need for the equipment ends. So in deciding whether to purchase equipment, you may wish to talk to your doctor about how long you may need it. Your social security office can also help when you have any questions.

3. ***What happens if I want to assign the payment to a doctor, but he doesn't want to accept an assignment?***
   That is his right. He does not have to take an assignment of your benefits. If your doctor doesn't agree to take your assignment, the payment will be made directly to you, whether or not the bill has been paid.

4. ***If I assign the benefit to my doctor or supplier, does this mean all my future benefit claims must also be handled on an assignment basis?***
   No. The payment can be made directly to your doctor or supplier one time and the next time it can be made to you.

5. ***I understand that the medical insurance benefits are paid on a "reasonable charge" basis. Who decides what the reasonable charge is, and how does this affect payment?***
   The carrier determines "reasonable charges" for covered services. If there is an assignment, the doctor or supplier agrees that the reasonable charge will be his total charge and that he will charge *you* only for any of the $60 deductible not yet met and 20 percent of the balance of the "reasonable charge." If there is no assignment, medical insurance can pay *you* only 80 percent of the reasonable charge (after the $60 deductible is met), even if the bill exceeds the "reasonable charge." (See page 15.)

6. ***What can I do if I disagree with the amount paid on my claim?***
   Write to the carrier which handled the claim and tell why you disagree with the amount allowed. If you are still not satisfied with the reply *and* the amount in question is $100 or more, you can request a hearing from the carrier.

7. ***Medicare does not pay all the doctor's bills. What can I do if I can't pay the rest?***
   If you do not have any other insurance or other resources with which you can pay the amounts due, you may want to ask at your public assistance office about help. The people there can give you information about a State program such as old-age assistance or medical assistance for the aged (sometimes called "medicaid").

Some Health Services and Items That NEITHER Hospital Insurance Nor Medical Insurance Will Pay For

Under each kind of benefit described in this handbook, there is a list of items and services that hospital insurance and medical insurance cannot pay. There are some other items or services that are not covered under either part of Medicare. These are shown in the following list:

- Services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.
- Cosmetic surgery—*except when furnished in connection with prompt repair of accidental injury or for the improvement of the functioning of a malformed body member.*
- Services for which neither the patient nor another party on his behalf has a legal obligation to pay—*such as free chest X-ray.*
- Certain services payable under other Federal, State, or local government programs.
- Services furnished by immediate relatives or members of the patient's household.

The First 3 Pints of Blood

Medicare cannot pay for the first 3 pints of whole blood (or units of packed red blood cells) that you receive either under hospital or medical insurance.

- Hospital insurance cannot pay for the first 3 pints of blood you receive in a *benefit period.* Usually, when you receive blood under hospital insurance it will be as a bed patient in a hospital.
- Medical insurance cannot pay for the first 3 pints of blood you receive in a *calendar year.* Usually, when you receive blood under medical insurance it will be in a doctor's office, a clinic, or the outpatient or emergency department of a hospital.

These are *separate* rules and they operate independently of each other. For example, if you receive blood under both hospital insurance and medical insurance, Medicare could not pay for the first 3 pints of blood under *either* program. But the blood you get under hospital insurance is fully paid for starting with the fourth pint during a benefit period; medical insurance will help pay for the blood you get starting with the fourth pint during a calendar year.

HOW TO GET HELP TO REPLACE BLOOD

Some people are able to arrange for the replacement of these first 3 pints of blood—that way they don't have to pay for them. There are two ways this can be done. First, you may arrange for replacement from a friend or relative or you may be a member of a blood donor group that will replace these first 3 pints of blood for you. Second—and this is often overlooked—your children (or your son-in-law or daughter-in-law) may belong to a blood replacement plan that includes you as a beneficiary. In that case, you would be eligible for blood on the basis of *their* membership.

You might want to check with your children and children-in-law about this so you'll have the information handy if you ever need it.

In almost all blood donor plans, blood replacement credit can be arranged anywhere in the United States.

DEPARTMENT OF
HEALTH, EDUCATION, AND WELFARE
SOCIAL SECURITY ADMINISTRATION
BALTIMORE, MARYLAND 21235

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